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SENATE BILL 838

By Briggs

AN ACT to amend Tennessee Code Annotated, Title 56 and Title 71, relative to coverage for behavioral health treatment.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

56-7-1018

(a) Every health insurance carrier that issues a health benefit plan under the jurisdiction of the department of commerce and insurance shall submit an annual report to the department on or before March 1 that contains the following information:

(1) The frequency with which the health insurance carrier required prior authorization for all prescribed procedures, services, or medications for mental health and alcoholism or drug dependence benefits during the previous calendar year and the frequency with which the health insurance carrier required prior authorization for all prescribed procedures, services, or medications for medical and surgical benefits during the previous calendar year. Health insurance carriers shall submit this information separately for inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits, and prescription drug benefits. The frequency shall be expressed as a percentage, with total prescribed procedures, services, or medications within each classification of benefits as the denominator and the overall number of times prior authorization was required for any

prescribed procedures, services, or medications within each corresponding classification of benefits as the numerator;

(2) A description of the process used to develop or select the medical necessity criteria for mental health and alcoholism or drug dependence benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(3) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health and alcoholism or drug dependence benefits and medical and surgical benefits;

(4) The results of an analysis that demonstrates that for the medical necessity criteria described in subdivision (a)(2) and for each NQTL identified in subdivision (a)(3), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL to mental health and alcoholism or drug dependence benefits are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL, as written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis shall:

(A) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

(C) Identify and describe the methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to design each NQTL as written for mental health and alcoholism or drug dependence benefits are comparable to and no more

stringent than the processes and strategies used to design each NQTL as written for medical and surgical benefits;

(D) Identify and describe the methods and analyses used, including the results of the analyses, to determine that processes and strategies used to apply each NQTL in operation for mental health and alcoholism or drug dependence benefits are comparable to and no more stringent than the processes or strategies used to apply each NQTL in operation for medical and surgical benefits; and

(E) Disclose the specific findings and conclusions reached by the health insurance carrier that the results of the analyses above indicate that the insurer or entity is in compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, and its implementing rules, including 45 CFR 146.136 and any other relevant current or future rules;

(5) The rates of and reasons for denial of claims for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs, and emergency care mental health and alcoholism or drug dependence services during the previous calendar year compared to the rates of and reasons for denial of claims in those same classifications of benefits for medical and surgical services during the previous calendar year;

(6) A certification signed by the health insurance carrier's chief executive officer and chief medical officer that affirms that the health insurance carrier has completed a comprehensive review of its administrative practices for the prior calendar year for compliance with the necessary provisions of this section, § 56-

7-2601, § 56-7-2602, and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. No. 110-343); and

(7) Any other information necessary to clarify data provided in accordance with this section requested by the commissioner, including information that may be "proprietary" or have "commercial value." Any information submitted that is proprietary shall not be made a public record under title 10, chapter 7.

(b) The commissioner shall not certify any health benefit plan of a health insurance carrier that fails to submit all data as required by this section.

(c) Separate NQTLs that apply to mental health and alcohol or drug dependence benefits but do not apply to medical and surgical benefits within any classification of benefits are not permitted.

(d) For the purposes of this section, "health insurance carrier" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner of commerce and insurance, that contracts with healthcare providers in connection with a plan of health insurance, health benefits, or health services.

SECTION 2. This act shall take effect January 1, 2018, the public welfare requiring it.